MASSACHUSETTS UNIFORM APPLICATION FOR PERMIT TO DO PLUMBING (Type or print) Date: Building Address___ Owners Name TOWN OF ACTON ☐ REPLACEMENT \square NEW ☐ RENOVATION **FIXTURES BATHTUBS** SHOWER STALLS SLOP SINKS **GAS TRAPS** BACKFLOW PREV OTHER FIXTURES DISPOSERS LAUNDRY TRAYS WASHING MACH. CONN HOT WATER TANKS FLOOR DRAINS AREA DRAIN WATER PIPING FLOOR DRAINS WATER CLOSETS KITCHEN SINKS LAVATORIES DISHWASHERS URINALS DRINKING FOUNTAIN IRRIGATION SYSTEM TANKLESS SUB-BSMT BASEMENT 1ST FLOOR 2ND FLOOR 3RD FLOOR 4TH FLOOR (Type or print) **Check One: Certificate** Installing Company Name_____ Corp. Address Partner Firm/Co Business Telephone____ Name of Licensed Plumber___ **Insurance Coverage:** Indicate the type of insurance coverage by checking the appropriate box: Liability Insurance policy -Other type of Indemnity -Bond Insurance Waiver: I, the undersigned, have been made aware that the licensee of this application does not have any one of the above three insurance coverages. -Owner -Agent Signature of owner/agent of property

FOR INSPECTION CALL
GARY COREY (978)263-5595

HOURS: 7:00 A.M. - 9:00 A.M.

plumbing Code and Chapter 142 of the General Laws.

Signature of Licensed Plumber

Type of Plumbing License

-Master -Journeyman

License Number

I hereby certify that all of the details and information I have submitted (or entered) in above application are true and accurate to the best of my knowledge and that all plumbing work and installations performed under Permit issued for this application will be in compliance with all pertinent provisions of the Massachusetts State



$The\ Commonwealth\ of\ Massachusetts$ Department of Industrial Accidents Office of Investigations 600 Washington Street

Boston, MA 02111

Town of Acton Workers' Compensation Insurance Affidavit

Applicant Information:	Please Print Legibly
Name:	
Location:	
City:	Phone #:
☐ I am a homeowner performing all work in	Phone #:myself.
\square I am a sole proprietor and have no one w	vorking in any capacity.
☐ I am an employer providing workers' co	empensation for my employees working on this job.
Company name:	
Address:	
	Phone #:
Insurance Co	Policy #:
🔲 I am a sole proprietor, general contra	ctor, or homeowner (circle one) and have hired the contractors
listed below who have the following wo	rkers' compensation policies:
Company name:	
Address:	
	Phone #:
Insurance Co	Policy #:
Company name:	
Address:	
City:	Phone #:
Insurance Co.	Policy #:
Attach additional sheet if necessary	
Failure to secure coverage as required under	Section 25 A of MGL 152 can lead to the imposition of
1 1	and/or one years' imprisonment as well as civil penalties in the
	of \$100.00 a day against me. I understand that a copy of this
statement may be forwarded to the Office of	Investigations of the DIA for coverage verification.
I do haraby cartify under the pains and pana	lties of perjury that the information provided above is true and
Tao nereby certify under the paths and pend	mes of perfury that the information provided above is true and
correct	
correct. Signature	Date
Signature	Date Phone #
Signature	Date Phone #
Signature_ Print name_ Official use only do not write in this area, to	Phone # be competed by city or town official
SignaturePrint name	Phone # be competed by city or town official Building Department
Signature_ Print name_ Official use only do not write in this area, to	Phone # be competed by city or town official
SignaturePrint namedo not write in this area, to permit/license #	Phone # be competed by city or town official Building Department Licensing Board Selectmen's Office Health Department